DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G037	A. BUILDING _____ B. WING _____	02/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	3815 ALBERMARLE STREET NW WASHINGTON, DC 20008

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W 000	INITIAL COMMENTS A recertification survey was conducted from February 19, 2009 through February 20, 2009. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a resident population of six males with various disabilities. The findings of the survey were based on observations, interviews with staff in the home and at three day programs, as well as a review of client and administrative records, including incident reports.	W 000	Received 4/6/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that staff working with clients at their day programs provided the appropriate level of assistance during meals, for one of the three clients in the sample. (Client #2) The finding includes: On February 19, 2009, Client #2 was observed at his day program from 10:53 AM - 12:47 PM. He and his peers started lunch at approximately 12:28 PM. Initially, he scooped his food independently using a plastic spoon and ate at a reasonable pace. Within a minute, however, a direct support staff person who was standing behind the client's right shoulder, took the client's right hand in his own hand. The staff held Client #2's hand back when he tried moving his hand towards the plate to obtain the next spoonful	W 120	Client #2 Day Program will be requested to send the QMRP and HM a copy of the written feeding program. Staff at the day program will receive additional training for supporting Client #2 mealtime. The QMRP and HM will visit the day program monthly to observe staff support for Client #2.	4/30/09

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese | TITLE: Program Director | (X6) DATE: 4/06/09

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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W 120	Continued From page 1 before he had finished chewing his food. The staff was stooped over, reaching behind the client's neck and had his left hand placed on the client's left shoulder. The staff was not positioned to see the client's mouth. As they proceeded with the meal, there were several occasions when the staff held the client's hand back, even though the client had finished swallowing his food. While the client applied greater force with his hand, trying to get the spoon over to the plate, the staff instructed him to "swallow first" and held his hand firmly back. The client's hand trembled while he looked up at the staff. This continued for approximately 5 minutes. The client kept looking up at the staff, first with a look of bewilderment, followed by facial expressions of frustration. The client eventually grabbed food off of his plate with his left hand. At approximately 12:50 PM, interview with the day program case manager revealed that Client #2 had a formal, written program for staff support during meals. He said staff were to sit next to the client, not stand, and to offer verbal cues to slow down if the client's eating pace grew too quickly. The case manager further indicated that the staff person had worked with the client "on and off for a couple of years" and had received training on the client's programs. In addition, he stated that the Qualified Mental Retardation Professional and House Manager had visited the day program. On February 20, 2009, at 2:51 PM, review of Client #2's individual program plan (IPP) dated September 5, 2008, confirmed that he had a goal to "consume his foods at an appropriate pace daily... A day program staff will sit next to <client's name> during his lunch and snacks/breaks... will	W 120		

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W 120	Continued From page 2 encourage <client's name> to slow down his eating pace using 4 verbal prompts when needed between bites of food..." The client's behavior support plan, dated May 8, 2008, addressed behaviors such as finger/thumb sucking, finger/hand biting, aggressive food grabbing and included the following statement: "Touch control or light physical redirection is allowed by BSP but only in the context of addressing incidents involving physical aggression." There was no evidence that the facility ensured that day program staff assisted with Client #2's meal only to the extent prescribed in his plan.	W 120		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, interviews with the Qualified Mental Retardation Professional (QMRP) and review of behavioral support plan (s) (BSP), the facility failed to demonstrate how the rights of all clients were protected, and failed to allow and encourage individual clients to exercise their rights as residents of the facility, and as citizens of the United States, for 5 of 6 clients residing in the facility. (Clients #1, #2, #3, #4 and #6) The finding includes: On February 20, 2009 at approximately 3:25 PM,	W 125	Each client's legal guardian and family will be made aware of the alarm use on all doors. A letter from HRC committee will be sent to all family members and legal guardians requesting their approval.	5/15/09

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W 125	Continued From page 3 during the environmental walk thru, there was an alarm that rang when the third level exit door was opened. Interview with the Qualified Mental Retardation Professional (QMRP) revealed that the alarm was placed on the door to address Client #5's target behavior of elopement. Further Interview with the QMRP revealed that she was unsure if the facility's Human Rights Committee (HRC) had approved the use of the door alarm. On February 19, 2009 at 12:59 PM, review of the HRC minutes for the periods of April 2008 thru January 2009, revealed that the HRC minutes dated November 20, 2008, had approved Client #5's Behavior Support Plan (BSP), which included elopement. Further review of the the HRC minutes failed to address the approval of the door alarm during the aforementioned review periods. Continued interview with the QMRP revealed she was unsure if the clients, legal guardians and/or involved family members had been made aware of the purpose of the door alarms and/or agreed to their use. At the time of the survey, there was no evidence that the clients legal guardians and/or involved family members were aware of the door alarm use.	W 125		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, staff interviews and record verification, the facility staff failed to demonstrate competency in the implementation	W 193		

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W 193	Continued From page 4 of behavior support plans (BSPs), for two of the three clients in the sample. (Clients #1 and #2) The findings include: Cross-refer to W249. On February 19, 2009, clients were observed in the facility from 6:25 AM - 9:03 AM and again from 4:07 PM - 6:38 PM. Observations that day revealed that staff failed to implement Clients #1's and #2's BSPs, as follows: 1. On February 19, 2009, beginning at 4:44 PM, Client #1 was observed sitting quietly with his 2 hands tucked under his buttock. At 5:00 PM, and again at 5:08 PM, he stood up from the chair, did a quick twirl and then sat back down, placing his hands back under his buttocks bot times. He was not engaged in a meaningful activity during that period. After dinner, Client #1 was again observed sitting on his hands for a 29 minute period (5:45 PM - 6:14 PM), and not engaged in activities. Client #1's BSP, dated November 17, 2008, included "sitting on hands" as a targeted behavior. The BSP stated that staff should "keep him busy. Keep his hands occupied... If he is seen sticking his hands underneath his seat, say 'stop'... distract him by telling him to do something that requires him to use his hands..." These intervention strategies were not employed by staff on that afternoon. 2. On February 19, 2009, staff failed to intervene when Client #2 repeatedly placed his fingers or thumbs in his mouth during the periods 4:12 PM-4:23 PM, 4:39 PM-5:11 PM and 5:29 PM-6:14 PM. At no time during those periods were staff observed intervening with his finger/ hand sucking and/or attempting to engage him in active treatment. Client #2's BSP, dated May 6, 2008,	W 193	1. All staff within the facility will receive training for Client #1's BSP by the behavioral specialist. The QMRP and HM will observe daily for implementation. Behavioral specialist will also review data forms. 2. All staff will receive training on Client #2's BSP. Behavioral specialist will also review the data forms.	4/6/09 4/6/09

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W 193	Continued From page 5 included the following: "... If <client's name> is observed starting to suck his fingers or thumb, staff should say 'stop <client's name>' and have him come over to them. Immediately verbally redirect him to do something else with his hands... work on one of the behaviors to increase..." These intervention strategies were not employed by staff that afternoon. 3. Client #2's BSP dated May 6, 2008 also included the target behavior of stealing foods from his peers. During dinner the night before, at 5:25 PM, Client #2 reached across the table from where he sat, quickly grabbed a slice of bread from Client #1's plate and put the entire slice into his mouth. There were several staff present; however, no staff attempted to intervene. In addition, staff failed to offer Client #1 another piece of bread, as was specified in the BSP. On February 19, 2009, beginning at 1:09 PM, review of staff in-service training records revealed no evidence that Staff A and Staff C had received training on the clients' BSPs. At 5:56 PM, interview with Staff A revealed that he had been working in this facility for approximately 2 months. The facility reportedly had not offered training to him regarding the BSPs. A few minutes later, Staff C said this was only her second day working in the facility. When asked about training re: the clients' BSPs, both staff confirmed that they had not received training on BSPs prior to working with the men.	W 193	3. Behavioral specialist will also address Client #2's target behavior of stealing food and recommend interventions to be used when he takes food from his peers.	4/6/09
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management.	W 247		

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W 247	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that each client was provided opportunities for choice, encouraged and taught to make choices for six of the six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6) The findings include: 1. The facility failed to ensure that each client was provided an opportunity to make a choice during snack time. (Clients #1, #2, #3, #4, #5 and #6) On February 19, 2009 at approximately 4:28 PM, staff was observed to give the clients a bowl of dried fruit with almonds and water to drink for snack. On February 20, 2009 at approximately 4:30 PM, clients were observed to eat dried fruit with almonds for their snack. Interview with the direct care staff on February 20, 2009 at 4:57 PM revealed the clients are offered other snacks to eat. During the environmental inspection on February 20, 2009, there were other snacks (i.e. chips, fruit, etc.) in the kitchen. At no time during snack time were the clients given the opportunity to select a snack from the variety of food choices. 2. The facility failed to ensure Client #2 and #4 were afforded opportunities for choice and/or self-management during dinner. During dinner on February 19, 2009 at approximately 4:57 PM, direct care staff was observed to prepare the dining table family style by placing a bowl of rice, a bowl of cabbage, pan of baked chicken, a bowl of baked beans, bread,	W 247	1. Staff will be trained by the nutritionist on how to give each client the opportunity to select a snack of his choice. QMRP and HM will monitor daily for implementation. 2. Client #2 and #4 will be given the opportunity to participate in family style dinning with hand over hand assistance from staff.	4/30/09 4/30/09

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W 247	Continued From page 7 and milk on the table. The staff was further observed to assist Client #1, #5, and #6 with scooping rice from the bowl to his plate. At 5:16 PM, staff was observed to serve Clients #2 and #4 dinner onto their plate. Although the dining table was set for family style dining, Clients #2 and #4 did not participate in the service of the food. Interview with the direct care staff on February 20, 2009 at approximately 5:00 PM, revealed that with some physical assistance, (i.e. hand over hand), Clients #2 and #4 could participate in serving their food during dinner time. At no time during the dinner meal were the clients given to opportunity to serve themselves. 3. The facility failed to ensure Client #2 was afforded opportunities for choice and/or self-management. On February 17, 2009, at 5:29 PM, Client #2 finished eating dinner and walked into the living room and took a seat. He placed his left fingers in his mouth (a maladaptive behavior targeted in his BSP), and remained without active engagement for the next 15 minutes. At 5:44 PM, he stood up and walked hurriedly into the kitchen. Staff B was wiping the sink at that time. Staff B looked up from his task and informed the surveyors that he had just heard the client say the word "water." Approximately 30 seconds later, however, he turned to the client and asked him what he wanted. Client #2 walked closer to him at the sink. The staff did not, however, offer opportunities for the client to exercise self-management (in this instance, obtain a glass of water and/or engage in household chores). A minute later, Client #2 left the kitchen and	W 247	3. Staff will be trained to assist Client #2 whenever he makes a request for water, and also to engage him in activities within the house. The QMRP and HM will monitor for implementation.	4/30/09

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W 247	Continued From page 8 returned to the living room, sat down and started rocking his body slightly. Staff B continued doing dishes at the kitchen sink. Client #2 was observed sucking on his fingers or thumb on and off until 6:11 PM.	W 247		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, facility staff failed to ensure continuous implementation of clients' behavior support plans, for two of the three clients in the sample. (Clients #1 and #2) The findings include: On February 19, 2009, clients were observed in the facility from 6:25 AM - 9:03 AM and again from 4:07 PM - 6:38 PM. During the Entrance Conference, at approximately 9:15 AM, the Qualified Mental Retardation Professional (QMRP) stated that all 6 clients had formal, written behavior support plans (BSPs). Observations later that day revealed that staff failed to implement the clients' BSPs, as follows: 1. On February 19, 2009, at 4:44 PM, Resident #1 sat in his 'favorite' chair in the living room after	W 249	Cross reference W193 (#1,#2,#3)	4/6/09

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W 249	Continued From page 9 he finished eating a snack. For the next 16 minutes, he was observed sitting quietly with his 2 hands tucked under his buttock. He was not engaged in a meaningful activity. At 5:00 PM, he stood up from the chair, did a quick twirl and then sat back down with his hands under his buttock. At 5:03 PM, Staff A, who was interacting with another resident nearby, asked Resident #1 to place his hands on his lap. The resident complied. The staff resumed interacting with the other resident but then Resident #1 promptly placed his hands back underneath his buttock. He remained without a meaningful activity. At 5:08 PM, he stood up , twirled once and then sat back down. Staff A saw the resident twirl and asked him if he wanted help with his belt. The resident stood up and the staff observed that his belt was OK. The resident sat down again and remained sitting quietly until he and his peers were called to dinner at 5:11 PM. Later, Client #1 was again observed sitting on his hands for a 29 minute period (5:45 PM until 6:14 PM), and not engaged in activities. It should be noted that Client #1 (nor his peers) were not asked to participate in pre or post-dinner activities. For example, Staff B was observed in the kitchen from approximately 5:34 PM - 6:14 PM, rinsing dishes at the sink, loading the dishwasher and wiping down the counters. Client #1's BSP was reviewed the next day, beginning at 2:19 PM. The BSP, dated November 17, 2008, included "sitting on hands" as a targeted behavior. The BSP stated that staff should "keep him busy. Keep his hands occupied. Watch him closely. When he looks as if he is bored or is beginning to start one of his maladaptive, challenging behaviors, hand him	W 249		

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W 249	Continued From page 10 something to do. Pay a lot of attention to him... If he is seen sticking his hands underneath his seat, say 'stop'... distract him by telling him to do something that requires him to use his hands..." 2. On February 19, 2009, staff failed to intervene with Client #2's targeted behavior of finger/ hand sucking in accordance with his BSP, as follows: 4:12 PM - Client #2 had his left thumb in his mouth while seated in the living room. He stood up and walked around the main floor of the facility for the next 5 minutes with his thumb in his mouth. No staff intervened. 4:17 PM - For a very brief moment, he removed his thumb while Staff A tied his shoe laces. Staff had not prompted him to remove the thumb. Once the shoe laces were tied, he put his thumb back into his mouth, and kept it there for the next 3 minutes without staff intervention. At 4:20 PM, Client #2 switched hands, placing his right thumb into his mouth for another 3 minutes. 4:23 PM - Afternoon snacks were announced and Staff A asked Client #2 to go with him to wash his hands. They left the living room together. He and the staff returned from the restroom approximately one minute later. The client was observed walking to the dining room with his index finger placed in his mouth. No staff intervened. 4:39 PM - After snack, Client #2 took a seat in the living room. He promptly put his left thumb in his mouth and kept it there for several minutes, biting on the nail. At 4:44 PM, Staff A walked towards him, looked directly at him but then continued walking past him without intervening. At 5:04 PM,	W 249		

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W 249	Continued From page 11 the client changed hands, placing his right thumb and fingers in his mouth. He was not engaged in a meaningful activity between 4:39 PM - 5:11 PM, when he and his peers were called to dinner. 5:29 PM - After dinner, Client #2 took a seat in the living room, placed his left fingers in his mouth, and remained without active engagement for the next 15 minutes. 5:50 PM - Client #2 stood gazing out the front window with his left thumb in his mouth for several minutes. He then stuck his right index finger into his right eye, then placed his right thumb in his mouth. He remained in the living room without a substantive activity for another 15 minutes. 6:14 PM - Client #2 and his peers were called to the basement for exercise and socialization. At no time during the previous 45 minutes, were staff observed intervening with his finger/ hand sucking and/or attempting to engage him in active treatment. Client #2's BSP was reviewed the next day, beginning at 2:40 PM. The BSP, dated May 6, 2008, included the following: "...prevent and reduce self-stimulating and self-injurious behaviors, the focus is often on the hand, fingers or thumb... If <client's name> is observed starting to suck his fingers or thumb, staff should say 'stop <client's name>' and have him come over to them. Immediately verbally redirect him to do something else with his hands... work on one of the behaviors to increase..." 3. Client #2's BSP dated May 6, 2008 also included the target behavior of stealing foods	W 249		

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W 249	Continued From page 12 from his peers. During dinner on the night before, at 5:25 PM, Client #2 reached across the table and quickly grabbed a slice of bread from Client #1's plate. He crammed the entire slice into his mouth and chewed quickly. There were several staff present at the time; however, the only person who attempted to intervene was Client #4 (reached for Client #2's hand, but missed it). Staff B, who had turned his attention in another direction, asked what had just occurred. Staff C informed him that Client #2 had taken #1's bread. Review of the BSP revealed the following: "If he actually takes food from someone, he should not be allowed to eat it. If the food gets handled by <client's name>, it should be discarded and the victim should get more." Staff did not offer Client #1 another piece of bread, or an appropriate substitute. It should be noted that interviews with Staff A and Staff C, followed by review of staff in-service training records, revealed that they had not received training on the clients' BSPs prior to working with the men. [See W193]	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to document behavior data in accordance with the behavior support plans (BSPs), for one of the three clients in the sample. (Client #2)	W 252	Cross reference W193 (#2)	4/6/09

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W 252	Continued From page 13 The findings include: 1. Cross-refer to W249.2. On February 19, 2009, Client #2 was observed engaged in one of the targeted behaviors (finger/ hand sucking) identified in his BSP (dated May 6, 2008). He placed either a thumb (left or right, alternating) or one or more fingers in his mouth from 4:12 PM-4:17 PM, 4:18-4:23 PM, at 4:24 PM, from 4:39-5:11 PM and through most of the period from 5:29 PM-6:14 PM. At no time during those periods were staff observed implementing the proactive or reactive components of the client's BSP. Client #2's BSP was reviewed the next day, beginning at 2:40 PM. The BSP included the following: "...Staff should document any episodes of finger or thumb sucking or finger or hand biting on the individualized data forms..." Subsequent review of the behavior data sheets, however, revealed that staff had entered a "3" for number of times they had observed the behavior. This, however, did not accurately represent the frequency of the behavior observed during that shift. 2. Cross-refer to W249.3. Client #2's BSP dated May 6, 2008 also included the target behavior of grabbing foods from his peers. At 5:25 PM on February 19, 2009, Client #2 grabbed a slice of bread from Client #1's plate and ate it. There were several staff present at the time and conversations between them indicated that they were aware that the incident had occurred. Review of the BSP revealed the following: "Incidents of food grabbing should be documented on the data forms in <client's name>	W 252		

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W 252	Continued From page 14 book." Subsequent review of the behavior data sheets, however, revealed that staff had entered a "0" as if they had not observed the behavior. It should be noted that interviews with Staff A and Staff C, followed by review of staff in-service training records, revealed that they had not received training on the clients' BSPs prior to working with the men. [See W193]	W 252		
W 338	483.460(c)(3)(v) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems). This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely medical services (specifically, laboratory studies), for two of the three clients in the sample. (Clients #1 and #2) The findings include: 1. Nursing staff failed to ensure that Client #1 received timely laboratory studies and/or clarified the physician's orders, as follows: a. On February 20, 2009, at 11:37 AM, review of Client #1's February 2009 physician's orders (POs) revealed a diagnosis on hypercholesterolemia and a low fat, low cholesterol diet order. The primary care physician (PCP) prescribed Zocor 40 mg every evening for the control of his serum cholesterol. The physician also ordered serum lipids and liver function tests (LFT) every 6 months. At 11:41	W 338		

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W 338	Continued From page 15 AM, review of lab reports in Client #1's medical chart revealed lipid levels and LFTs were tested on January 18, 2008 and July 8, 2008. There was no written evidence of more recent tests. b. At approximately 12:10 PM, review of Client #1's Health Management Care Plan (HMCP) revealed that the RN had reviewed it on December 11, 2008. The HMCP reflected the findings of the July 8, 2008 labs. Further review of the HMCP, however, revealed that the nurse had not documented an anticipated follow-up date for obtaining and updated lipid panel. In addition, the nurse had written "N/A" in the column regarding obtaining an updated liver function test. c. At 12:50 PM, when asked whether Client #1 had received serum lab tests in January of February 2009 (specifically lipids and LFTs), the House Manager (HM) reviewed the medical chart and stated that the physician had ordered those tests annually. He pointed to Client #1's Annual Medical Evaluation, dated July 11, 2008, in which the PCP recommended "CBC, CMP, lipid panel, TSH with Free T4 annually." The annual evaluation did not, however, address LFTs. It did include "hypercholesterolemia, obesity ..." among the diagnoses listed. d. Client #1's past POs were then reviewed. The oldest POs in his chart were dated July 2008. Beginning with the July 2008 POs and each month since then, his POs reflected an ongoing order for the lipids and LFT testing every 6 months. They had all been signed by the RN and the PCP. e. There was no evidence that the nursing staff sought clarification from the PCP regarding	W 338	1. (a~~+~~b) The primary nurse will review Client #1 HMCP to ensure PCP's order for lab tests are incorporated into the HMCP.	4/15/09
			(c~~+~~d~~+~~e) Client #1 Lipid panel and LFT's were done on 2/28/09. In the future, the RN supervisor will make the lab schedule for all the clients to be followed by the primary nurse and /or the QMRP. The RN supervisor will review the clients medical record and quarterly basis to ensure investigation and follow-ups are done in a timely manner.	4/15/09

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W 338	Continued From page 16 discrepancies between the ordered frequencies of labs on the POs (every 6 months) versus the recommendation on the annual medical evaluation (annual labs). No additional information was presented before the survey ended later that evening. 2. Nursing staff failed to schedule follow-up laboratory tests in accordance with Client #2's PCP instructions. On February 20, 2009, at 3:30 PM, review of the client's August 22, 2008 test reports revealed that the PCP had circled 2 test results that were flagged by the laboratory as abnormal. The liver enzyme Alanine transaminase (ALT) tested "High" 54 IU/L (reference value 13-51 IU/L) and his hemoglobin (HGB) was "low" 12.7 GM/DL (reference 13.0-16.2 G/DL). A third, unidentifiable factor (a hole was punched through the name/identifier) had also tested " Low " 38.7% (reference value 39.3-47.3%). The PCP had circled the 3 items and wrote "Repeat" and/or "Repeat fasting" next to them. In addition, the test report indicated that urinalysis had not been performed "test cancelled-patient unable to void." Further review of Client #2's medical chart revealed no written evidence that the labs had been repeated, as ordered by the PCP. At approximately 4:10 PM, the RN was asked on the telephone whether Client #2 had returned for repeat lab testing since the August 22, 2008 tests. She stated that she did not recall his receiving additional labs; however, she would ask the Director of Nursing. No additional information was presented before the survey ended later that evening.	W 338	**The RN supervisor will review the medical assessments and the physicians order sheet for any discrepancies and will get clairification from the PCP.** 4/2/09 **2. Client #2's requested lab work was completed. Nursing staff will review medical records monthly to review PCP orders for lab follow-up.** 2/25/09	
W 340	483.460(c)(5)(i) NURSING SERVICES	W 340		

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W 340	Continued From page 17 Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nursing staff failed to provide training on hand washing procedures and infection control, for two newly-hired staff and three of the six clients residing in the facility. (Staff A and Staff C; and Clients #2, #5 and #6) The findings include: Cross-refer to W455. On February 19, 2009, clients and staff were observed in the facility between 4:07 PM - 6:44 PM. Staff A and Staff C did not encourage Clients #2 and #5 to wash their hands at appropriate times, such as when they put their fingers into ears, noses and throats. In addition, staff failed to utilize effective techniques to ensure that Client #6 washed his hands before eating. On February 19, 2009, beginning at 1:09 PM, review of staff in-service training records, followed by staff interviews at 5:56 PM revealed that facility nurses had not provided training on infection control to the 2 newly-hired staff prior to their assignment to work in the facility.	W 340	The nursing staff will provide in-service training for the staff on infection control. The QMRP and HM will ensure that all employees receive required trainings, during initial orientation period by monitoring all training sheets.	4/6/09
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security.	W 381		

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W 381	Continued From page 18 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to store drugs under proper conditions of security for one of six clients residing in the facility. (Client #4) The finding includes: On February 20, 2009, during the environmental inspection at 3:25 PM, a bottle of Shampoo (Ketoconazole 2%) and Protopic (Tacrolimus 0.1% ointment) for Client #4 was observed in a container on top of his dresser. Interview with the Nurse revealed that the facility had not developed a policy for allowing the drugs in the client's bedroom. There was no evidence that all drugs were stored under proper conditions of security.	W 381	All topical medication will be secured within a designated location.	4/6/09
W 426	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that the temperature of the water did not exceed 110 degrees Fahrenheit. The finding includes: On February 19, 2009, at approximately 2:57 PM, the water temperature in the sink in the bathroom on the main hallway upstairs felt hot to the touch. At 3:10 PM, the water temperature in that sink measured 121 degrees Fahrenheit. Water in the	W 426	The House Manager and Evening Supervisor will ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. Water temperature will be checked daily by QMRP, HM, or Evening and Night Managers.	4/6/09

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W 426	Continued From page 19 nearby bathtub registered 130 degrees Fahrenheit. Water in the kitchen sink also registered 130 degrees Fahrenheit. Interview with facility's House Manager (HM) at approximately 3:15 PM revealed that he would adjust the thermostat on the hot water heater himself. The HM presented a hot water temperature log in which "night supervisors" reportedly documented hot water temperature tests. Review of the log revealed the same reading, 110 degrees Fahrenheit, had been recorded on February 2, 3, 4, 5, 8, 11, 12, 14 and 18, 2009. No other readings were recorded for that month. The HM further indicated that the night supervisors utilized thermometers that they carried with them. At 3:20 PM, the HM retrieved a thermometer from his desk and took readings of 120 degrees Fahrenheit in the bathroom hand sink and 130 degrees Fahrenheit in the kitchen sink, thereby reaffirming the readings taken earlier by the surveyor. At 3:23 PM, the HM stated that he had just adjusted the hot water heater and he expected that it would be at 110 degrees or below before the clients' return home later that afternoon. On February 20, 2009, at approximately 3:30 PM, the temperature of the hot water in the kitchen sink registered at 113 degrees Fahrenheit and the water in the bathtub in the main hallway upstairs was 112 degrees Fahrenheit. The HM made yet another adjustment to the thermostat and the reading at the kitchen sink, taken at approximately 5:51 PM, was 110 degrees and the bathtub 109 degrees Fahrenheit.	W 426		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the	W 455	Cross reference W340	4/6/09

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W 455	Continued From page 20 prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide training for staff and clients regarding infection control procedures (hand washing specifically), to prevent communicable infectious diseases, for two newly-hired staff and three of the six clients residing in the facility. (Staff A and Staff C; and Clients #2, #5 and #6) The findings include: On February 19, 2009, clients and staff were observed in the facility between 4:07 PM - 6:44 PM. Staff did not encourage clients to wash their hands at appropriate times to ensure sanitation, as follows: 1. At 4:09 PM, Client #5 was seated in the living room, along with 2 of his peers and Staff C. He put a finger into his nose, then into his right ear, then back into his nose again and repeated this procedure several times. He then rubbed the top of his head with both hands, followed then by rubbing on his neck and the inside collar of his shirt. Staff did not intervene. Client #5 pointed at a drawing book and made signs with his hands. This surveyor asked if he had been signing "wash hands." Staff C, who was sitting nearby and had seen Client #5's finger in his nose and ear, turned to him and repeated the question, "wash hands?" The client did not respond. The staff then stated that she thought he had been requesting crayons. She handed some crayons to him, without first	W 455	1. Cross reference W340	4/6/09

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W 455	Continued From page 21 instructing him to wash his hands. 2. Cross-refer to W249.2. Client #2 was observed with either a thumb (left or right, alternating) or one or more fingers in his mouth for the following periods: from 4:12 PM-4:17 PM, 4:18-4:23 PM, at 4:24 PM, from 4:39-5:11 PM and through most of the period from 5:29 PM-6:14 PM. Staff did not instruct him to stop and have him wash his hands, in accordance with his behavior support plan. The only times that staff instructed him to wash his hands was at 4:23 PM, when they called him and his peers to the dining room for afternoon snack and at 5:11 PM, when dinner was served. At other times, however, he walked freely though the living room and elsewhere, touching furniture and other objects with his hands. 3. At 4:29 PM, Staff C told Client #6 "Let's go wash our hands." At the time, he was seated in a chair near the archway between the living room and the dining room. The client protested loudly and refused to leave the chair. The staff responded "OK, ready when you are." Approximately 1 minute later, he got up and made continuous protestations as he went into the kitchen with Staff C. However, he returned to the chair in the living room a few minutes later and sat again. The staff said he had refused to wash his hands. A moment later, Staff A carried a bowl that contained dried fruit and nut mix from the dining room over to the client and gave him the bowl. Client #6 stood up and carried the bowl to the dining room table and proceeded to eat without having washed his hands. Staff A had not offered any instructions to Client #6 or encouragement for him to wash his hands before he handed him his snack.	W 455	2. Cross reference W249.2 3. Cross reference W340	4/6/09 4/6/09

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W 455	Continued From page 22 4. On February 19, 2009, beginning at 1:09 PM, review of staff in-service training records revealed no evidence that Staff A and Staff C had received training on infection control. At 5:56 PM, interview with Staff A revealed that he had been working in this facility for approximately 2 months. The facility reportedly had not offered training for him on infection control. A few minutes later, Staff C said this was only her second day working in the facility. Both staff confirmed that neither one had been offered training re: infection control prior to working with the men.	W 455	4. Cross reference W340	4/6/09

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I 000	INITIAL COMMENTS A licensure survey was conducted from February 19, 2009 through February 20, 2009. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a resident population of six males with various disabilities. The findings of the survey were based on observations, interviews with staff in the home and at three day programs, as well as a review of client and administrative records, including incident reports.	I 000		
I 022	3501.5 ENVIRONMENTAL REQ / USE OF SPACE Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the window located in the kitchen had blinds and/or curtains . The finding includes: On February 20, 2009 at approximately 3:32 PM, an environmental walk-through of the interior of the GHRMP revealed the window located in the kitchen was observed without blinds, shades, and/or curtains. The neighbors backyard was clearly visible when standing in the kitchen. Interview with the Qualified Mental Retardation Professional (QMRP) at approximately 3:33 PM acknowledged that the kitchen window was without a cover, to ensure the residents' privacy.	I 022	**All blinds will be replaced at the kitchen window.**	**2/24/09**
I 091	3504.2 HOUSEKEEPING Housekeeping and maintenance equipment shall	I 091		

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I 091	Continued From page 1 be well constructed, properly maintained and appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observations and interview, the GHRMP failed to maintain the interior and exterior of the GHMRP in a safe, clean, orderly, attractive, and sanitary manner. The findings include: Observation and interview with the Qualified Mental Retardation Professional (QMRP) during the environmental walk through on February 20, 2009 beginning at approximately 3:10 PM revealed the following. 1. The sink in the bathroom located on the second level was observed with very slow drainage. The water remained in the sink approximately one and half minutes before draining completely. 2. There was a box spring located in Resident #3's bedroom that was occupying additional space. Interview with the QMRP/House Manager (HM) revealed that there were no current plans to add a mattress to the box spring. The QMRP stated that the box spring will be removed. 3. There were two screws sticking out approximately a half to a quarter inch of the wall located in bathroom #1 to the right of the mirror.	I 091	1. The sink in the bathroom on the second level was repaired to increase drainage flow. 4/1/09 2. The box spring and bed frame in #3's bedroom will be removed. 4/3/09 3. The two screws will be adjusted to fit properly in the wall to the right of the mirror. 4/1/09	
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s	I 206		

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I 206	Continued From page 2 certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties for eight (8) of thirty-one (31) personnel records reviewed. The finding includes: Interview with the House Manager and review of the personnel records on February 20, 2009, beginning at 2:42 PM, revealed the GHMRP failed to provide evidence that current health certificates were on file for 9 of 13 direct care staff (Staffs #A, #C, #E, #F, #G, #H, #K, #L, and #M).	I 206	**The facility will ensure that employees' health certificates will be kept current by checking personnel records monthly. All health certificates will be placed in each employees personnel record.**	**5/15/09**
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;	I 227	**Cross reference W1206. Also the facility will ensure that all employees have current First Aid and CPR training certificate on file by reviewing monthly.**	**5/15/09**

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I 227	Continued From page 3 This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to effectively train staff to implement emergency measures for six of the six residents of the facility. (Residents #1, #2, #3, #4, #5 and #6) The findings include: On February 20, 2009 beginning at 2:42 PM, interview with the Qualified Mental Retardation Professional (QMRP) and review of staff and consultant records revealed the following: 1. There was no documented evidence of current CPR certification and/or First Aid training for 5 of the 13 Direct Care Aide (DCA) staff who had been employed for longer than 90 days. (Staff #B, #C, #E, #H, and #K) 2. There was no documented evidence of current CPR certification and/or First Aid training for 1 of the 5 nursing staff who had been employed for longer than 90 days. (Consultant #A)	I 227	Consultant #A will provide proof of CPR and First Aid certification. The RN supervisor will monitor the nursing staff personnel record quarterly to ensure license, CPR and First Aid, health certificate are current.	4/30/09
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observations, staff interviews and record verification, the facility staff failed to demonstrate competency in the implementation	I 229	Cross reference W193 (#1,#2,#3) Also staff received additional required training on BSP and sexuality. Staff will receive nutritional training.	4/6/09 3/27/09 4/6/09

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I 229	Continued From page 4 of behavior support plans (BSPs), for two of the three residents in the sample. (Residents #1 and #2) The findings include: Cross-refer to I422. On February 19, 2009, residents were observed in the facility from 6:25 AM - 9:03 AM and again from 4:07 PM - 6:38 PM. Observations that day revealed that staff failed to implement Residents #1's and #2's BSPs, as follows: 1. On February 19, 2009, from 4:44 PM - 5:00 PM, Resident #1 was observed sitting quietly with his 2 hands tucked under his buttock. At 5:00 PM, he stood up from the chair, did a quick twirl and then sat back down on his hands. He repeated that procedure at 5:08 PM. He was not engaged in a meaningful activity during that 24-minute period. After dinner, Resident #1 was again observed sitting on his hands for a 29 minute period (5:45 PM - 6:14 PM), and not engaged in activities. Resident #1's BSP, dated November 17, 2008, included "sitting on hands" as a targeted behavior. The BSP stated that staff should "keep him busy. Keep his hands occupied... If he is seen sticking his hands underneath his seat, say 'stop'... distract him by telling him to do something that requires him to use his hands..." These intervention strategies were not employed by staff on that afternoon. 2. On February 19, 2009, staff failed to intervene when Resident #2 repeatedly placed his fingers or thumbs in his mouth during the periods 4:12 PM-4:23 PM, 4:39 PM-5:11 PM and 5:29 PM-6:14 PM. At no time during those periods were staff observed intervening with his finger/ hand sucking and/or attempting to engage him in	I 229	1. Cross reference W193 (#1) 2. Cross reference W193 (#2)	4/6/09 4/6/09

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I 229	Continued From page 5 active treatment. Resident #2's BSP, dated May 6, 2008, included the following: "... If <resident's name> is observed starting to suck his fingers or thumb, staff should say 'stop <resident's name>' and have him come over to them. Immediately verbally redirect him to do something else with his hands... work on one of the behaviors to increase..." These intervention strategies were not employed by staff that afternoon. 3. Resident #2's BSP dated May 6, 2008 also included the target behavior of stealing foods from his peers. During dinner the night before, at 5:25 PM, Resident #2 reached across the table from where he sat, quickly grabbed a slice of bread from Resident #1's plate and put the entire slice into his mouth. There were several staff present; however, no staff attempted to intervene. In addition, staff failed to offer Resident #1 another piece of bread, as was specified in the BSP. On February 19, 2009, beginning at 1:09 PM, review of staff in-service training records revealed no evidence that Staff A and Staff C had received training on the residents' BSPs. At 5:56 PM, interview with Staff A revealed that he had been working in this facility for approximately 2 months. A few minutes later, Staff C said this was only her second day working in the facility. When asked about training re: the residents' BSPs, both staff confirmed that they had not received training on BSPs prior to working with the men. According to the staff, the facility had not offered training regarding the residents' BSPs.	I 229	3. Cross reference W193 (#1,#2)	4/6/09
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis	I 401		

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I 401	Continued From page 6 and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely medical services (specifically, laboratory studies), for two of the three residents in the sample. (Residents #1 and #2) The findings include: 1. Nursing staff failed to ensure that Resident #1 received timely laboratory studies and/or clarified the physician's orders, as follows: a. On February 20, 2009, at 11:37 AM, review of Resident #1's February 2009 physician's orders (POs) revealed a diagnosis on hypercholesterolemia (among others) and a low fat, low cholesterol diet order. The primary care physician (PCP) prescribed Zocor 40 mg every evening for the control of his serum cholesterol. The physician also ordered serum lipids and liver function tests (LFT) every 6 months. At 11:41 AM, review of lab reports in Resident #1's medical chart revealed lipid levels and LFTs were tested on January 18, 2008 and July 8, 2008. There was no written evidence of more recent tests. b. At approximately 12:10 PM, review of Resident #1's Health Management Care Plan (HMCP) revealed that the RN had reviewed it on December 11, 2008. The HMCP reflected the findings of the July 8, 2008 labs. Further review of the HMCP, however, revealed that the nurse	I 401	1. Cross reference W338	4/15/09

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I 401	Continued From page 7 had not documented an anticipated follow-up date for obtaining and updated lipid panel. In addition, the nurse had written "N/A" in the column regarding obtaining an updated liver function test. c. At 12:50 PM, when asked whether Resident #1 had received serum lab tests in January of February 2009 (specifically lipids and LFTs), the House Manager (HM) reviewed the medical chart and stated that the physician had ordered those tests annually. He pointed to Resident #1's Annual Medical Evaluation, dated July 11, 2008, in which the PCP recommended "CBC, CMP, lipid panel, TSH with Free T4 annually." The annual evaluation did not, however, address LFTs. It did include "hypercholesterolemia, obesity ..." among the diagnoses listed. d. Resident #1's past POs were then reviewed. The oldest POs in his chart were dated July 2008. Beginning with the July 2008 POs and each month since then, his POs reflected an ongoing order for the lipids and LFT testing every 6 months. They had all been signed by the RN and the PCP. e. There was no evidence that the nursing staff sought clarification from the PCP regarding discrepancies between the ordered frequencies of labs on the POs (every 6 months) versus the recommendation on the annual medical evaluation (annual labs). No additional information was presented before the survey ended later that evening. 2. Nursing staff failed to schedule follow-up laboratory tests in accordance with Resident #2's PCP instructions. On February 20, 2009, at 3:30	I 401	2. Cross reference W338	4/15/09

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I 401	Continued From page 8 PM, review of the resident's August 22, 2008 test reports revealed that the PCP had circled 2 test results that were flagged by the laboratory as abnormal. The liver enzyme Alanine transaminase (ALT) tested "High" 54 IU/L (reference value 13-51 IU/L) and his hemoglobin (HGB) was "low" 12.7 GM/DL (reference 13.0-16.2 G/DL). A third, unidentifiable factor (a hole was punched through the name/identifier) had also tested " Low " 38.7% (reference value 39.3-47.3%). The PCP had circled the 3 items and wrote "Repeat" and/or "Repeat fasting" next to them. In addition, the test report indicated that urinalysis had not been performed "test cancelled-patient unable to void." Further review of Resident #2's medical chart revealed no written evidence that the labs had been repeated, as ordered by the PCP. At approximately 4:10 PM, the RN was asked on the telephone whether Resident #2 had returned for repeat lab testing since the August 22, 2008 tests. She stated that she did not recall his receiving additional labs; however, she would ask the Director of Nursing. No additional information was presented before the survey ended later that evening.	I 401		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interviews and record review, facility staff failed to ensure continuous implementation of residents' behavior support plans, in accordance with their Individual Support Plans, for two of the three residents in the	I 422		

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I 422	Continued From page 9 sample. (Residents #1 and #2) The findings include: On February 19, 2009, residents were observed in the facility from 6:25 AM - 9:03 AM and again from 4:07 PM - 6:38 PM. During the Entrance Conference, at approximately 9:15 AM, the Qualified Mental Retardation Professional (QMRP) stated that all 6 residents had formal, written behavior support plans (BSPs). Observations later that day revealed that staff failed to implement the residents' BSPs, as follows: 1. On February 19, 2009, at 4:44 PM, Resident #1 sat in his 'favorite' chair in the living room after he finished eating a snack. For the next 16 minutes, he was observed sitting quietly with his 2 hands tucked under his buttock. He was not engaged in a meaningful activity. At 5:00 PM, he stood up from the chair, did a quick twirl and then sat back down with his hands under his buttock. At 5:03 PM, Staff A, who was interacting with another resident nearby, asked Resident #1 to place his hands on his lap. The resident complied. The staff resumed interacting with the other resident but then Resident #1 promptly placed his hands back underneath his buttock. He remained without a meaningful activity. At 5:08 PM, he stood up , twirled once and then sat back down. Staff A saw the resident twirl and asked him if he wanted help with his belt. The resident stood up and the staff observed that his belt was OK. The resident sat down again and remained sitting quietly until he and his peers were called to dinner at 5:11 PM. Later, Resident #1 was again observed sitting on his hands for a 29 minute period (5:45 PM until 6:14 PM), and not engaged in activities.	I 422	Cross reference W193 (#2)	4/6/09

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I 422	Continued From page 10 Resident #1's BSP was reviewed the next day, beginning at 2:19 PM. The BSP, dated November 17, 2008, included "sitting on hands" as a targeted behavior. The BSP stated that staff should "keep him busy. Keep his hands occupied. Watch him closely. When he looks as if he is bored or is beginning to start one of his maladaptive, challenging behaviors, hand him something to do. Pay a lot of attention to him... If he is seen sticking his hands underneath his seat, say 'stop'... distract him by telling him to do something that requires him to use his hands..." Staff did not, however, employ those strategies on February 19, 2009. It should be noted that Resident #1 was not asked to participate in pre or post-dinner activities. For example, Staff B was observed in the kitchen from approximately 5:34 PM - 6:14 PM, rinsing dishes at the sink, loading the dishwasher and wiping down the counters. 2. On February 19, 2009, staff failed to intervene with Resident #2's targeted behavior of finger/ hand sucking in accordance with his BSP, as follows: 4:12 PM - Resident #2 had his left thumb in his mouth while seated in the living room. He stood up and walked around the main floor of the facility for the next 5 minutes with his thumb in his mouth. No staff intervened. 4:17 PM - For a very brief moment, he removed his thumb while Staff A tied his shoe laces. Staff had not prompted him to remove the thumb. Once the shoe laces were tied, he put his thumb back into his mouth, and kept it there for the next 3 minutes without staff intervention. At 4:20 PM,	I 422	2. Cross reference W193 #2	4/6/09

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I 422	Continued From page 11 Resident #2 switched hands, placing his right thumb into his mouth for another 3 minutes. 4:23 PM - Afternoon snacks were announced and Staff A asked Resident #2 to go with him to wash his hands. They left the living room together. He and the staff returned from the restroom approximately one minute later. The resident was observed walking to the dining room with his index finger placed in his mouth. No staff intervened. 4:39 PM - After snack, Resident #2 took a seat in the living room. He promptly put his left thumb in his mouth and kept it there for several minutes, biting on the nail. At 4:44 PM, Staff A walked towards him, looked directly at him but then continued walking past him without intervening. At 5:04 PM, the resident changed hands, placing his right thumb and fingers in his mouth. He was not engaged in a meaningful activity between 4:39 PM - 5:11 PM, when he and his peers were called to dinner. 5:29 PM - After dinner, Resident #2 took a seat in the living room, placed his left fingers in his mouth, and remained without active engagement for the next 15 minutes. 5:50 PM - Resident #2 stood gazing out the front window with his left thumb in his mouth for several minutes. He then stuck his right index finger into his right eye, then placed his right thumb in his mouth. He remained in the living room without a substantive activity for another 15 minutes. 6:14 PM - Resident #2 and his peers were called to the basement for exercise and socialization. At no time during the previous 45 minutes, were	I 422		

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I 422	Continued From page 12 staff observed intervening with his finger/ hand sucking and/or attempting to engage him in active treatment. Resident #2's BSP was reviewed the next day, beginning at 2:40 PM. The BSP, dated May 6, 2008, included the following: "...prevent and reduce self-stimulating and self-injurious behaviors, the focus is often on the hand, fingers or thumb... If <resident's name> is observed starting to suck his fingers or thumb, staff should say 'stop <resident's name>' and have him come over to them. Immediately verbally redirect him to do something else with his hands.... work on one of the behaviors to increase..." Staff did not, however, employ those strategies on February 19, 2009. 3. Resident #2's BSP dated May 6, 2008 also included the target behavior of stealing foods from his peers. During dinner on the night before, at 5:25 PM, Resident #2 reached across the table and quickly grabbed a slice of bread from Resident #1's plate. He crammed the entire slice into his mouth and chewed quickly. There were several staff present at the time; however, the only person who attempted to intervene was Resident #4 (reached for Resident #2's hand, but missed it). Staff B, who had turned his attention in another direction, asked what had just occurred. Staff C informed him that Resident #2 had taken #1's bread. Review of the BSP revealed the following: "If he actually takes food from someone, he should not be allowed to eat it. If the food gets handled by <resident's name>, it should be discarded and the victim should get more." Staff did not offer Resident #1 another piece of bread, or an appropriate substitute.	I 422	2. Cross reference W193 #2	4/6/09